Senate Bill No. 59

Passed the Senate September 10, 1999

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Secretary of the Senate

Passed the Assembly September 9, 1999

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Chief Clerk of the Assembly

This bill was received by the Governor this _____ day

of _____, 1999, at _____ o'clock ____M.

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Private Secretary of the Governor

CHAPTER _____

An act to add Section 1367.01 to, and to repeal and add Section 1363.5 of, the Health and Safety Code, to add Section 10123.135 to the Insurance Code, and to add Section 14087.41 to the Welfare and Institutions Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 59, Perata. Health care coverage.

(1) Existing law provides for the regulation of health care service plans by the Department of Corporations and for the regulation of disability insurers by the Department of Insurance. Existing law requires a health care service plan to disclose the process used by the plan to authorize or deny health care services, to the Commissioner of Corporations, health care providers under contract with the plan, and enrollees, as specified, and establishes the criteria used by plans to determine whether to authorize or deny health care services. Existing law requires a health care service plan and a disability insurer to include within its disclosure form and evidence or certificate of coverage a statement describing how participation may affect the choice of physicians. Existing law provides that a willful violation of provisions regulating health care service plans is a crime.

This bill would instead require a health care service plan to disclose the process the plan, its contracting provider groups, or any entity with which the plan contracts for services, uses to authorize, modify, or deny health care services, to health care providers, enrollees, or to any other person or organization upon request, and would revise the criteria or guidelines used by plans, or any entities with which plans contract for utilization review or utilization management functions, to determine whether to authorize, modify, or deny health care services.

This bill would enact additional provisions applicable to a health care service plan and any entity with which it

contracts for services, that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based on medical necessity, requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees or other specified entities. It would require that those decisions be made within specified timeframes. These provisions would not apply to certain decisions made for the care or treatment of the sick who depend upon prayer or spiritual means for healing in the practice of religion. The bill would also enact similar provisions applicable to a disability insurer that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based on medical necessity, requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to insureds, or other specified entities. It would require that those decisions be made within specified timeframes. Because a violation of the bill's requirements with respect to health care service plans would be a crime, this bill would create a state-mandated local program by creating a new crime.

This bill would also make legislative findings and declarations in this regard.

(2) Existing law provides for the Medi-Cal program to provide health coverage for low-income persons.

This bill would require the State Department of Health Services to develop a simple form to be used by Medi-Cal managed care plans in order to notify an enrollee of a denial, termination, delay, or modification in benefits, as specified.

(3) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

The people of the State of California do enact as follows:

SECTION 1. (a) The Legislature finds and declares all of the following:

(1) Consumers have the right to receive quality medical care in a timely and efficient manner.

(2) Decisions about medical care should be made by physicians and other relevant health care professionals.

(3) Consumers have the right to know how and why a decision about their medical care is made.

(b) ''Utilization review,'' otherwise known as ''internal review,'' is the process by which health care service plans and disability insurers review, and approve, modify, or deny, requests for treatment of patients by physicians, and the Legislature recognizes that it is an integral component of the total process by which consumers access health care services.

(c) It is the intent of the Legislature to establish sound consumer protections applicable to the internal review processes of health care service plans and disability insurers, with the goal of providing faster, more accessible, and better quality medical care to patients.

SEC. 2. Section 1363.5 of the Health and Safety Code is repealed.

SEC. 3. Section 1363.5 is added to the Health and Safety Code, to read:

1363.5. (a) A plan shall disclose or provide for the disclosure to the director and to network providers the process the plan, its contracting provider groups, or any entity with which the plan contracts for services that include utilization review or utilization management functions, uses to authorize, modify, or deny health care services under the benefits provided by the plan, including coverage for subacute care, transitional inpatient care, or care provided in skilled nursing facilities. A plan shall also disclose those processes to enrollees or persons designated by an enrollee, or to any other person or organization, upon request.

(b) The criteria or guidelines used by plans, or any entities with which plans contract for services that

include utilization review or utilization management functions, to determine whether to authorize, modify, or deny health care services shall:

(1) Be developed with involvement from actively practicing health care providers.

(2) Be consistent with sound clinical principles and processes.

(3) Be evaluated, and updated if necessary, at least annually.

(4) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the enrollee in that specified case.

(5) Be available to the public upon request. A plan shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. A plan may charge reasonable fees to cover administrative expenses related to disclosing criteria or guidelines pursuant to this paragraph, limited to copying and postage costs. The plan may also make the criteria or guidelines available through electronic communication means.

(c) The disclosure required by paragraph (5) of subdivision (b) shall be accompanied by the following notice: ‘‘The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract.’’

SEC. 4. Section 1367.01 is added to the Health and Safety Code, to read:

1367.01. (a) Every health care service plan and any entity with which it contracts for services that include utilization review or utilization management functions, that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees, or that delegates these functions to medical groups or

independent practice associations or to other contracting providers, shall comply with this section.

(b) A health care service plan that is subject to this section shall have written policies and procedures establishing the process by which the plan prospectively, retrospectively, or concurrently reviews and approves, modifies, or delays or denies, based in whole or in part on medical necessity, requests by providers of health care services for plan enrollees. These policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes developed pursuant to Section 1363.5. These policies and procedures, and a description of the process by which the plan reviews and approves, modifies, delays, or denies requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees, shall be filed with the director for review and approval, and shall be disclosed by the plan to providers and enrollees upon request, and by the plan to the public upon request.

(c) Every health care service plan subject to this section shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 of the Business and Professions Code or pursuant to the Osteopathic Act, or, if the plan is a specialized health care service plan, a clinical director with California licensure in a clinical area appropriate to the type of care provided by the specialized health care service plan. The medical director or clinical director shall ensure that the process by which the plan reviews and approves, modifies, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees, complies with the requirements of this section.

(d) If health plan personnel, or individuals under contract to the plan to review requests by providers, approve the provider’s request, pursuant to subdivision

(b), the decision shall be communicated to the provider pursuant to subdivision (h).

(e) No individual, other than a licensed physician or a licensed health care professional, as required by Section 733, 2052.1, or 2052.2 of the Business and Professions Code, who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an enrollee for reasons of medical necessity. The decision of the physician or other health care professional shall be communicated to the provider and the enrollee pursuant to subdivision (h).

(f) The criteria or guidelines used by the health care service plan to determine whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees, shall be consistent with clinical principles and processes developed pursuant to the requirements of Section 1363.5.

(g) If the health care service plan requests medical information from providers in order to determine whether to approve, modify, or deny requests for authorization, the plan shall request only the information reasonably necessary to make the determination.

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees, based in whole or in part on medical necessity, every health care service plan subject to this section shall meet the following requirements:

(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with, the provision of health care services to enrollees that do not meet the requirements for the 72-hour review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the enrollee’s condition, not to exceed five business days from the plan’s receipt of the information reasonably necessary and requested by the plan to make the determination. In cases where the review is retrospective, the decision shall

be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law. For purposes of this section, retrospective reviews shall be for care rendered on or after January 1, 2000.

(2) When the enrollee's condition is such that the enrollee faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decisionmaking process, as described in paragraph (1), would be detrimental to the enrollee's life or health or could jeopardize the enrollee's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours after the plan's receipt of the information reasonably necessary and requested by the plan to make the determination. Nothing in this section shall be construed to alter the requirements of subdivision (b) of Section 1371.4. Notwithstanding Section 1371.4, the requirements of this division shall be applicable to all health plans and other entities conducting utilization review or utilization management.

(3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to enrollees shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the enrollee's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the enrollee in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the enrollee's treating provider has been notified of the

plan's decision, and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees, shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees, shall be communicated to the enrollee in writing and to providers initially by telephone, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the plan's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the enrollee may file a grievance with the plan pursuant to Section 1368, and in the case of Medi-Cal enrollees, shall explain how to request an administrative hearing and aid paid pending under Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations.

(5) If the health care service plan cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the plan is not in receipt of all of the information reasonably necessary and requested, or because the plan requires consultation by an expert reviewer, or because the plan has asked that an additional examination or test be performed upon the

enrollee, provided the examination or test is reasonable and consistent with good medical practice, the plan shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2) or as soon as the plan becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the enrollee, in writing, that the plan cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The plan shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the plan, the plan shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.

(6) If the director determines that a health care service plan has failed to meet the timeframes specified in paragraph (1) or (2), whichever applies, or has failed to meet any other requirement of this section, the director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, an opportunity for a hearing with regard to, the person affected, in accordance with subdivision (a) of Section 1397. The administrative penalties shall not be deemed an exclusive remedy for the director. These penalties shall be paid to the State Managed Care Fund.

(i) Every health care service plan subject to this section shall maintain telephone access for providers to request authorization for health care services.

(j) Every health care service plan subject to this section that reviews requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall establish, as part of the quality assurance program required by Section 1370, a process by which the plan’s compliance with this section

is assessed and evaluated. The process shall include provisions for evaluation of complaints, assessment of trends, implementation of actions to correct identified problems, mechanisms to communicate actions and results to the appropriate health plan employees and contracting providers, and provisions for evaluation of any corrective action plan and measurements of performance.

(k) The director shall review a health care service plan's compliance with this section as part of its periodic onsite medical survey of each plan undertaken pursuant to Section 1380, and shall include a discussion of compliance with this section as part of its report issued pursuant to that section.

(*l*) This section shall not apply to decisions made for the care or treatment of the sick who depend upon prayer or spiritual means for healing in the practice of religion as set forth in subdivision (a) of Section 1270.

(m) Nothing in this section shall cause a health care service plan to be defined as a health care provider for purposes of any provision of law, including, but not limited to, Section 6146 of the Business and Professions Code, Sections 3333.1 and 3333.2 of the Civil Code, and Sections 340.5, 364, 425.13, 667.7, and 1295 of the Code of Civil Procedure.

SEC. 5. Section 10123.135 is added to the Insurance Code, to read:

10123.135. (a) Every disability insurer, or an entity with which it contracts for services that include utilization review or utilization management functions, that covers hospital, medical, or surgical expenses and that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to insureds, or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.

(b) A disability insurer that is subject to this section, or any entity with which an insurer contracts for services that include utilization review or utilization management functions, shall have written policies and procedures establishing the process by which the insurer prospectively, retrospectively or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity requests by providers of health care services for insureds. These policies and procedures shall ensure that decisions based on medical necessity of a proposed health care service are consistent with criteria or guidelines that are supported by clinical principles and processes developed pursuant to subdivision (f). These policies and procedures, and a description of the process by which an insurer or any entities with which insurers contract for services that include utilization review or utilization management function, reviews and approves, modifies, or denies requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to insureds, shall be filed with the commissioner, and shall be disclosed by the insurer to insureds and providers upon request, and by the insurer to the public upon request.

(c) If the number of insureds covered under health benefit plans in this state that are issued by an insurer subject to this section constitute at least 50 percent of the number of insureds covered under health benefit plans issued nationwide by that insurer, the insurer shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 of the Business and Professions Code or the Osteopathic Act, or the insurer may employ a clinical director licensed in California whose scope of practice under California law includes the right to independently perform all those services covered by the insurer. The medical director or clinical director shall ensure that the process by which the insurer reviews and approves, modifies, or denies, based in whole or in part on medical necessity requests by providers prior to, retrospectively, or concurrent with, the provision of

health care services to insureds, complies with the requirements of this section. Nothing in this subdivision shall be construed as restricting the existing authority of the Medical Board of California.

(d) If an insurer subject to this section, or individuals under contract to the insurer to review requests by providers, approve the provider's request pursuant to subdivision (b), the decision shall be communicated to the provider pursuant to subdivision (h).

(e) No individual, other than a licensed physician or a licensed health care professional, as required by Sections 733, 2052.1, or 2052.2 of the Business and Professions Code who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may deny or modify requests for authorization of health care services for an insured for reasons of medical necessity. The decision of the physician or other health care provider shall be communicated to the provider and the insured pursuant to subdivision (h).

(f) (1) An insurer shall disclose or provide for the disclosure to the commissioner and to network providers, the process the insurer, its contracting provider groups, or any entity with which it contracts for services that include utilization review or utilization management functions, uses to authorize, modify, or deny health care services under the benefits provided by the insurance contract, including coverage for subacute care, transitional inpatient care, or care provided in skilled nursing facilities. An insurer shall also disclose those processes to policyholders or persons designated by a policyholder, or to any other person or organization, upon request.

(2) The criteria or guidelines used by insurers, or any entities with which insurers contract for utilization review or utilization management functions, to determine whether to authorize, modify, or deny health care services shall:

(A) Be developed with involvement from actively practicing health care providers.

(B) Be consistent with sound clinical principles and processes.

(C) Be evaluated, and updated if necessary, at least annually.

(D) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the policyholder in that specified case.

(E) Be available to the public upon request. An insurer shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. An insurer may charge reasonable fees to cover administrative expenses related to disclosing criteria or guidelines pursuant to this paragraph, limited to copying and postage costs. The insurer may also make the criteria or guidelines available through electronic communication means.

(3) The disclosure require by subparagraph (E) of paragraph (2) shall be accompanied by the following notice: ‘‘The materials provided to you are guidelines used by this insurer to authorize, modify, or deny health care benefits for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your insurance contract.

(g) If an insurer subject to this section requests medical information from providers in order to determine whether to approve, modify, or deny requests for authorization, the insurer shall request only the information reasonably necessary to make the determination.

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to insureds, based in whole or in part on medical necessity, every insurer subject to this section shall meet the following requirements:

(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with, the provision of health care services to

insureds that do not meet the requirements for the 72-hour review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the insured's condition, not to exceed five business days from the insurer's receipt of the information reasonably necessary and requested by the insurer to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law. For purposes of this section, retrospective reviews shall be for care rendered on or after January 1, 2000.

(2) When the insured's condition is such that the insured faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decisionmaking process, as described in paragraph (1), would be detrimental to the insured's life or health or could jeopardize the insured's ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to insureds shall be made in a timely fashion, appropriate for the nature of the insured's condition, but not to exceed 72 hours after the insurer's receipt of the information reasonably necessary and requested by the insurer to make the determination.

(3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to insureds shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the insured's treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the insured in writing

within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the insured's treating provider has been notified of the insurer's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to insureds, shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with, the provision of health care services to insureds, shall be communicated to insureds in writing to providers initially by telephone except with regard to decisions rendered retrospectively and then in writing, shall include a clear and concise explanation of the reasons for the insurer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification or a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the provider or the insured may file an appeal with the insurer or seek department review under the unfair practices provisions of Article 6.5 (commencing with Section 790) of Chapter 1 of Part 7 of Division 1 and the regulations adopted thereunder.

(5) If the insurer cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the insurer is not in receipt of all of the information reasonably necessary and requested, or because the insurer requires consultation by an expert reviewer, or

because the insurer has asked that an additional examination or test be performed upon the insured, provided that the examination or test is reasonable and consistent with good medical practice, the insurer shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2), or as soon as the insurer becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the insured, in writing, that the insurer cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The insurer shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the insurer, the insurer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.

(6) If the commissioner determines that an insurer has failed to meet the timeframes specified in paragraph (1) or (2), whichever applies, or has failed to meet any other requirement of this section, the commissioner may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, an opportunity for a hearing with regard to, the person affected. The administrative penalties shall not be deemed an exclusive remedy for the commissioner. These penalties shall be paid to the State Insurance Fund.

(i) Every insurer subject to this section shall maintain telephone access for providers to request authorization for health care services.

(j) Nothing in this section shall cause a disability insurer to be defined as a health care provider for purposes of any provision of law, including, but not limited to, Section 6146 of the Business and Professions Code, Sections 3333.1 and 3333.2 of the Civil Code, and

Sections 340.5, 364, 425.13, 667.7, and 1295 of the Code of Civil Procedure.

SEC. 6. Section 14087.41 is added to the Welfare and Institutions Code, to read:

14087.41. The department shall develop a simple form, consistent with the notice requirements of Sections 51014.1 and 51014.2 of Title 22 of the California Code of Regulations, for Medi-Cal managed care plans to use to notify a Medi-Cal enrollee of a denial, termination, delay, or modification in benefits. The department shall require all Medi-Cal managed care plans to use the form as a condition of participation in Medi-Cal managed care pursuant to any contract negotiated after the effective date of this section.

SEC. 7. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

Approved _____, 1999

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Governor